MOOD DISORDERS

Introduction

Children, like adults, experience depression and accompanying feelings of frustration, disappointment or sadness. The American Academy of Child & Adolescent Psychiatry (AACAP) estimates that, at any given time, approximately five percent of children and adolescents suffer from depression (2004). Unfortunately, children may not be able to accurately describe their symptoms or how they feel and frequently do not understand the concepts associated with being depressed.

According to research conducted by the Virginia Treatment Center for Children (2002), mood disorders in children are prevalent but often poorly recognized. Mood disorders manifest themselves in varying forms and with varying intervals and intensity. Also, the symptoms of mood disorders in children are different from those in adults, with mood disorders often accompanied by other psychiatric disorders which can mask depressive symptoms (Brown, 1996). Furthermore, many physicians regard depression and bipolar disorder as illnesses affecting adults. Until the 1980's, mood disorders were not included in the category of childhood diagnosed psychiatric illnesses (Brown). Table 1 lists the prevalence of mood disorders in children.

According to Brown (1996), the following behaviors may be associated with mood disorders in children:

Preschool Children

These children exhibit a dismal appearance and may be less lively when compared to their peers. They also may be tearful or spontaneously irritable, not just upset when they do not get their way. Furthermore, these children make frequent negative self-statements and are often self-destructive.

Preschool Children *(continued)*

The following information is taken from Luby et al. (2003). A key symptom for identifying depression in preschoolers is anhedonia–the inability to experience pleasure from activities and play. Another symptom is the use of play to explore themes about death and even suicide. Preschool children suffering from depression experience less joy from the pleasures of daily life and do not derive pleasure from the same things that typically please a 3 to 5 year old child.

Elementary School-Aged Children and Adolescents

These children may exhibit disruptive behavior, academic difficulties, and peer problems. Other symptoms include irritability and aggression, suicidal threats, and worsening school performance. Parents often say that nothing pleases the children; the children may state that they hate themselves and everything around them.

Table 1

Prevalence of Mood Disorders in Children

- 10 to 15% of all children and adolescents will experience some symptoms of depression.
- 7 to 14% of children will experience an episode of major depression before the age of 15.
- 20 to 30% of adult bipolar patients report having their first episode before the age of 20.
- Out of 100,000 adolescents, 2,000 to 3,000 will have mood disorders; of this number, 8 to 10 will commit suicide.

Source: Brown, 1996 and the Substance Abuse and Mental Health Services Administration (SAMHSA), *Major Depression in Children and Adolescents,* 2003.

The following paragraphs address major depression, dysthymia and bipolar disorders. The following are descriptions of these classifications as outlined by the Center for Advancement of Children's Mental Health at Columbia University (2000) and Wisconsin United for Mental Health (2002):

Major depressive disorder – Major depressive disorder is characterized by one or more major depressive episodes, lasting from 7 to 9 months on average. Depressed children exhibit symptoms of sadness, disinterest, and are critical of themselves. They may feel unloved, pessimistic, or hopeless. Additionally, they think that life is not worth living and have suicide thoughts. Depressed children and adolescents are often irritable and aggressive and may be indecisive, have concentration problems, lack energy, and exhibit irregular sleep habits. Associated anxiety symptoms include fears of separation or reluctance to meet people, and physical symptoms, such as general aches and pains, stomachaches, and headaches. In fact, such physical symptoms are more common in depressed children than in adults with depression.

Dysthymia – This disorder is less severe than major depressive disorder, but still involves long-term, chronic symptoms that are not disabling, but keeps a child from functioning well or feeling good. Many children with dysthymia also experience major depressive episodes at some time in their lives. The average duration of a dysthymic period in children is about four years and, frequently, the child is depressed for such a long period that they do not perceive that their mood is unusual. Accordingly, they may not complain of feeling depressed. Seventy percent of children and adolescents with dysthymia eventually experience an episode of major depression.

Bipolar disorder – Bipolar disorder is another type of depression, also called manic-depressive illness. This disorder is not as prevalent as other forms of depressive disorders. Bipolar disorder is characterized by shifts of mood with severe highs (mania) and extreme lows (depression). Frequently the mood

switches are rapid, but are usually gradual in nature. When in a depressed episode, the child may have any or all of the symptoms of a depressive disorder. When in the manic episode, the child may be overactive, over talkative, and have a great deal of energy. Symptoms of mania may affect thinking, judgment, and social behavior in ways that cause serious problems and even embarrassment. Episodes of mania may develop into psychosis, which causes the child to lose of touch with reality. Moreover, hallucinations or delusions may accompany mania.

Once regarded as a rare occurrence in children, bipolar disorder is indicated in approximately seven percent of children in treatment in psychiatric facilities (National Alliance for the Mentally Ill [NAMI], 2004). Frequently, the bipolar disorder begins in adolescence, with the first onset being a depressive episode. The first manic features may not occur for months or years later. There may be behavioral differences in children having bipolar disorder, which distinguishes it from the disorder in adults (Child and Adolescent Bipolar Foundation, 2002). Frequently, the symptoms of both states occur together in varied stages (depressed mood with high energy) or in quick succession within a single day (called rapid cycling) (Child and Adolescent Bipolar Foundation). The cycling may be fast (often many times a day) and the episodes are short (rarely more than days of any one state) (Chandler, 2001). Evidence indicates that bipolar disorder beginning in childhood or adolescence may also be more severe than the form of bipolar disorder associated with older adolescent and adult-onset (Focus on Adolescent Services, 2000).

Causes and Risk Factors

According to the U.S. Department of Health and Human Services (1999), the exact causes of mood disorders are not known. While research on adults indicates that contributing factors may be both biological and psychosocial, there has been little research on the causes of depression in children. Research has been conducted on children admitted in mental health clinics diagnosed with major depressive disorder and, while these may be the more severe cases, this research revealed that 20 to 50% of these children have a family history of depression (Puig-Antich et al., Todd et al., Williamson et al., Kovacs, as cited by the U.S. Department of Health and Human Services). Children who develop major depression are more likely to have a family history of the disorder than children having onset of depression in adolescence or adulthood (National Institute of Mental Health [NIMH], 2000). However, research did not shed light on whether the ties between family history and childhood onset of depression stem from genetic factors, or whether depressed parents create an environment that increases the likelihood of their children developing a mental disorder (U.S. Department of Health and Human Services, 1999).

Research has revealed that bipolar disorder may have a significant genetic connection. According to study data cited in 2002 by the Child and Adolescent Bipolar Foundation:

- When one parent has bipolar disorder, the risk to each child is 15 to 30%.
- When both parents have bipolar disorder, the risk increases to 50 to 75%.
- The risk in siblings and fraternal twins is 15 to 25%. The risk in identical twins is approximately 70%.
- Bipolar disorder can skip generations and take different forms in different individuals.

Family history of drug or alcohol abuse may also be associated with bipolar disorders in teens (AACAP, 1998).

According to Murphy et al. (2001), neurotransmitter evidence points to “abnormalities amine neurotransmitters as medicators of depressive states.” Furthermore, the evidence strongly points to deficiencies in norepinephrine and serotonin. Finally, other neuroendocrine anomalies in the

hypothalamic-pituitary-adrenal axis are present in depression, which indicates a link to neuroendocrine.

The U.S. Department of Health and Human Services (1999) outlines several different causes for mood disorders and indicates that the prevailing hypothesis is that mood disorders are caused by an absolute or relative deficiency of monoamine transmitters in the brain. Although there are questions about this being the primary cause, findings have confirmed that monoamine impairment is one the manifestations, or correlates, of depression.

Women are two or three times more likely to experience a major depressive episode in the course of their lifetime (Obesity, Fitness & Wellness Week, 2004). A new study examining the link between mood disorders and females has determined that there may be a connection between mood disorders and fluctuating estrogen and progesterone levels (Obesity, Fitness & Wellness Week). The Child and Adolescent Bipolar Foundation has suggested that the onset of menstruation may trigger the disorder in females (2002). Additional research is needed to determine specific genetic markers to understand the balance between estrogen, progesterone, testosterone, and other reproductive hormones and the increase of women's susceptibility to depression (Obesity, Fitness & Wellness Week).

According to research compiled by NIMH (2000), during childhood boys and girls are equally at risk for mood disorders. However, during adolescence, girls are twice as likely as to develop depression. Other risk factors compiled by the NIMH include:

- Stress;
- Cigarette smoking;
- Loss of a parent or loved one;
- Break-up of a romantic relationship;
- Attention, conduct or learning disorders;
- Chronic illnesses, such as diabetes;
- Abuse or neglect; and
- Other trauma, including natural disasters.

Comorbidity

Research compiled by the U.S. Department of Health and Human Services (1999) asserts that two-thirds of children with mood disorders usually have another mental disorder. These findings also assert that the most commonly associated disorders are dysthymia, anxiety disorders, disruptive disorders, and a substance abuse disorder. Additional research indicates that, when more than one diagnosis is present, depression is more likely to begin after the onset of the comorbid disorder. The exception to this is substance abuse. Additionally, conduct disorder may arise independently in response to inadequate parental supervision and control. Depression is also often comorbid with eating, reading, and developmental disorders, as well as general medical conditions (Klein et al., 2005). As noted previously, there are a number of possible reasons for these high comorbidity rates, including one disorder causing another or splitting what is really a single category, such as internalizing disorders, into multiple subtypes, such as depression and generalized anxiety disorder (e.g., some forms of anxiety leading to depression) (Klein). Table 2 outlines comorbidity and mood disorders.

Table 2

Comorbidity and Mood Disorders

- 40 to 70% of depressed children and adolescents may have comorbid psychiatric disorders.
- 30 to 80% have comorbid anxiety disorders.
- 10 to 80% have disruptive disorders (ADHD, oppositional defiant disorder).
- 20 to 40% involve substance abuse.

Source: Yaylayan, 2002.

Individuals diagnosed with bipolar disorder have an alcoholism rate and a drug-abuse rate that is triple the rest of the population (Kluger & Song, 2002). Accordingly, this must be considered in the evaluation of children for bipolar disorder.

Diagnosis

Proper assessment of mood disorders in children is essential in early intervention and treatment. According to the AACAP (1998), various mechanisms may be employed in diagnosing mood disorders in children. One of the most useful methods is the comprehensive psychiatric diagnostic evaluation, including interviews with the child, parents, and additional interviewees such as teachers and social services personnel. The behavior of depressed children and adolescents differs from that of depressed adults, making diagnosis more difficult (AACAP, 2004). The psychiatric assessment of depressed children must be performed by a clinician trained to consider how developmental and cultural factors impact the display of symptoms and the child. Additionally, it is important for the clinician to appraise the child's functioning, as well as symptoms both initially and on an ongoing basis. This is necessary in order to monitor the child's response to treatment.

Bipolar Disorder

The following information is attributed to the Substance Abuse and Mental Health Services Administration (*Mood Disorders,* 2003). Even though research indicates that bipolar disorder may be caused by a chemical imbalance, currently there are no lab tests used for diagnosis. This disease may often go unrecognized by the individual, as well as by family and friends A complete medical evaluation is needed in order to rule out other possible mental of physical disorders. A psychiatrist trained for diagnosis and treatment of bipolar disorder should be consulted for accurate diagnosis. When diagnosing bipolar disorder, evaluations of frequency, intensity, number of symptoms are essential (Hitti, 2005).

In diagnosed bipolar disorder, one of the biggest challenges has been to differentiate children with mania from those with attention deficit hyperactivity disorder (ADHD). Both groups of children present with irritability, hyperactivity and distractibility, these symptoms are not useful for the diagnosis of mania because they also occur in ADHD. Elated mood, grandiose behaviors, flight of ideas, decreased need for sleep and hypersexuality occur primarily in mania and are uncommon in ADHD (NAMI, 2004).

Depression

For diagnosis of depression, four or more of the following symptoms should be present for more than two weeks: a change in appetite, change in sleeping patterns, feelings of worthlessness, inappropriate guilt, loss of pleasure or interest in activities, fatigue, lack of concentration, sadness, disturbed thinking, headaches, stomach aches, or suicidal thoughts or behaviors (SAMHSA, *Mood*

Disorders, 2003). Major depression is characterized by far more severe symptoms, such as being unable to get out of bed (SAMHSA). Other symptoms include tearfulness, insomnia, obsessive rumination, and physical complaints (American Psychiatric Association, 2000). If one or more of these indicators are present, parents should seek professional guidance immediately.

Treatment Considerations

Mood Disorders and Suicide in Children

The U.S. Department of Health and Human Services (1999) asserts that mood disorders dramatically increase the risk of suicide. Accordingly, the potential for suicidal behavior is a grave matter and must be taken into account by service providers treating the child. Studies have shown that 90% of children who commit suicide have a mental disorder. In a 10- to 15-year study of 73 adolescents diagnosed with major depression, seven percent of the adolescents had committed suicide sometime later. The depressed adolescents were five times more likely to have attempted suicide, compared to adolescents who do not have depression (Weissman et al., as cited by the U.S. Department of Health and Human Services). The relationship between mood disorders and suicide is explained in the *Collection's* "Youth Suicide" section.

Recurrence of Mood Disorders

Additionally, the U.S. Department of Health and Human Services (1999) states that most children with depression will encounter a recurrence. Data indicates that 20 to 40% of depressed children relapse within two years, and 70% relapse by adulthood (Garber et al., Velez et al., Harrington et al., Fleming et al., Kovacs et al., Lewinsohn et al., Garrison et al., as cited by the U.S. Department of Health and Human Services). The reasons for relapse are not known, but evidence supports the theory that depression may render some type of psychological imprint which can increase vulnerability to relapse. Depression which co-occurs with conduct disorder appears to worsen this outcome, as does the presence of conflict in the family.

Variables that may impact recovery time include age of onset, severity of depression, suicidality, the presence of comorbid anxiety or conduct disorders (CD), and an adverse family environment (Birmaher et al., as cited by Klein, 2005). Most of these factors also predict recurrence. Variables that have been associated with an increased risk of recurrence include the above-listed factors as well as the presence of symptoms after recovery, recent stressful life events, and a family history of depression, particularly if it is recurrent (Birmaher et al., as cited by Klein).

Prognosis of Mood Disorders in Treatment

The U.S. Department of Health and Human Services (1999) states that the prognosis for dysthymia (Klein et al., as cited by the U.S. Department of Health and Human Services) is dim, with most children experiencing depression and other difficulties even after they have apparently recovered. The prognosis for major depressive disorder plus dysthymia is significantly worse than for either condition alone (Kovacs et al., as cited by the U.S. Department of Health and Human Services).

Development of Other Mood Disorders

Research compiled in the Surgeon General's Report (1999) reveals that 20 to 40% of children with depression may develop bipolar disorder. Contributing factors predicting this outcome include young age at the time of the first depressive episode, psychotic features in the initial depression, a family history of bipolar illness, and symptoms of hypomania developing during treatment with

antidepressant drugs (Garber et al., Strober et al., as cited by the U.S. Department of Health and Human Services).

Selection of Appropriate Interventions

Based on studies reviewed by the AACAP (1998), treatment should be tailored and based on several factors. These include the treatment setting, the chronic nature of the disorder, the classification of the mood disorder (e.g., bipolar, dysthymia, and major depressive disorder), the age of the child, and family issues. Based on the formation and context of mood disorders in general, pharmacotherapy is usually not advised without accompanying psychosocial treatments. Moreover, with the high rate of comorbidity and the potential for serious outcomes, such as suicidal ideation or behavior, a multi-modal treatment approach is preferred. The practice parameter published by the AACAP recommends children continue therapy for at least six to twelve months to help achieve remission and to prevent recurrence.

The following information is taken from Klein et al. (2005). There are high rates of relapse and recurrence when psychosocial and pharmacological treatments are terminated. Unfortunately, there are few studies on maintenance of treatment for depressed children and adolescents. Based on findings from adult studies, it may be beneficial to consider continuation and maintenance treatment for children and adolescents with partial recovery or characteristics associated with an increased risk of recurrence. These factors include history of recurrent episodes, double depression, family history, ongoing family conflict, or other stressors. Data on predictors of treatment response in depressed children and adolescents is limited. However, it appears that many of the same variables that predict a more protracted recovery in naturalistic studies also predict a poorer response to treatment. A strategy may be to incorporate the child or adolescent's deficits to guide treatment.

Treatment of Depressive Disorders

Analysis conducted by Burns et al. (1999) indicates that evidence-based treatments have emerged for childhood mood disorders. Furthermore, such treatments are well established for both psychosocial and pharmacological interventions. This is beneficial in that combining the two offers maximum therapeutic benefits.

Because children who experience the onset of mood disorders at a younger age have a worse prognosis, early intervention is crucial in treatment (Brown, 1996). Early clinical intervention is critical in order to prevent additional functional breakdown, relapse and suicidal behavior (Burns et al., 1999).

The NIMH (2000) asserts that treatment for depressive disorders in children and adolescents often involves short-term psychotherapy, medication, or a combination, and targeted interventions involving the home or school environment. There are specific treatments for depression that have displayed efficacious results.

Psychosocial Treatments

In an analysis of research of major depressive disorder and children, Burns et al. (1999) found that cognitive behavioral therapy (CBT) was efficacious in rendering positive treatment results. Almost all of the clinical trials in school-aged children have used CBT for children with symptoms of, but not necessarily a diagnosis of, depression. The majority of studies have reported evidence supporting the efficacy of CBT (Klein et al., 2005). Little is known about the mechanisms

underlying the effects of CBT and interpersonal therapy on depression in children and adolescents (Klein et al.). In addition, despite the efficacy of psychosocial interventions for depressed children and adolescents in clinical trials, there is evidence that this may not translate into effectiveness in community settings (Weisz et al., as cited by Klein et al.).

Among the numerous studies reviewed in the Surgeon General's Report (1999), one form of CBT—coping skills—was judged probably efficacious. However, this intervention, based on the "Coping with Depression" course, was developed originally in Oregon for adults by Lewinsohn and colleagues (Lewinsohn, as cited by the U.S. Department of Health and Human Services). It was later utilized effectively in school-based programs to treat depression in children. The children receiving this treatment, when compared with control groups, had lower rates of depression, less self-reported depression, improvement in cognitive activity and increased activity levels.

Further findings revealed that interpersonal therapy (IPT) showed promise in the treatment of children with major depressive disorder (Society of Clinical Child and Adolescent Psychology, 2006). For depressed teenagers, IBT is a well-established treatment which helps adolescents understand and address problems in their relationships so that they can become less depressed. Typically, IPT takes place in an individualized format, in which the clinician works one-on-one with the child and his or her family.

Pharmacological Treatments

According to the U.S. Department of Health and Human Services (1999), the medications formerly selected for treating major depression in children were the tricyclic antidepressants. However, trials in children, unlike trials performed on adults, did not indicate that tricyclic antidepressants were efficacious. Additionally, tricyclic antidepressants have a higher risk of toxicity than selective serotonin reuptake inhibitors (SSRIs) (Walsh et al., Kutcher, as cited by the U.S. Department of Health and Human Services). Therefore, tricyclic medications are not the medication of choice for treating major depressive disorder in children and should be avoided in youth who are at risk for suicidal behaviors (Benton, 2006). Recent research indicates that young people with depressive disorders may respond more favorably to SSRIs than to tricyclic antidepressants. However, controlled clinical trials of antidepressant medications in children and adolescents are limited, and data on SSRIs and atypical antidepressants is mixed (Klein et al., 2005).

Some studies have found SSRIs to be effective for the treatment of children and adolescents with depression. Moreover, SSRIs have a relatively safe adverse effect profile and typically require only once daily administration (Benton). Some studies reported only partial improvements when SSRIs were utilized (Benton, 2006). One explanation for the partial response is that the effective treatment may involve varying the dosage or length of treatment (Benton). Findings from these studies also indicate that the ideal treatment likely involves a combination of pharmacologic and psychosocial interventions (Benton). As stated previously, there is great promise with several types of CBTs for children, along with efficacy being established that supports the utilization of SSRIs (U.S. Department of Health and Human Services, 1999).

There is no data on the efficacy of treatments for very young children with depression (Weisz et al., as cited by Klein et al., 2005). There is also limited evidence regarding the use of stimulants, antidepressants and other psychiatric drugs in preschoolers (Weisz et. al, as cited by Klein et al.). However, child mental health professionals have developed recommendations to help clinicians who are considering medications for children ages three to six (Lifespan, 2007). These guidelines

emphasize family-focused assessment by experienced clinicians, the use of psychosocial interventions, and the value of monitoring of symptoms and side effects (Klein).

Antidepressants and the Risk of Suicidal Behavior

The information discussed below is attributed to Gould et al. (2004). There has been considerable debate about the use of antidepressants in treating children and adolescents with depression and whether the use of SSRIs increases the risk of suicidal behaviors. Some researchers assert that increased prescriptions of SSRIs have resulted in decreased suicide rates. However, findings from randomized controlled trials reveal that certain medications are contraindicated for youth under 18 years of age. Manufacturers in the United States are now required to place a "black box" warning label on these medications. Clinicians must weigh the risks of SSRIs against the potential benefits that these drugs may offer their patients. A further description of the use of antidepressants in treating children and adolescents is included in the "Antidepressants and the Risk of Suicidal Behavior" section of the *Collection*.

Treatment of Bipolar Disorder

Psychosocial Treatments

According to analyses conducted by the Center for the Advancement of Children's Mental Health of Columbia University (2000), there are no consistent positive trials of psychosocial treatments for children diagnosed with bipolar disorder. However, children with bipolar disorder show benefit from a combination of psychosocial treatments and medication (Kutcher, 2002). Treatment planning should include pharmacologic, social, vocational, academic and interpersonal components. This is due to the fact that the depressive episodes are more frequent occurrences than the manic episodes and also more difficult to treat (Kutcher).

Pharmacological Treatments

According to the NIMH (2000), treatment of children diagnosed with bipolar disorder is modeled after treatment experiences with adults because there is limited research on the safety and efficacy of mood stabilizing medications in youth. The treatment of bipolar disorder in adults involves the use of appropriate doses of mood stabilizing medications, typically lithium or valproate, both of which are found to be effective for controlling mania and preventing recurrences of manic and depressive episodes in adults. Researchers currently are evaluating both pharmacological and psychosocial interventions for bipolar disorder in children and adolescents.

The U.S. Department of Health and Human Services (1999) indicates that recent research conducted on the use of lithium in children has shown this intervention to have promising results in treating children with bipolar disorder. However, children experience the same safety problems with lithium that adults may experience, such as toxicity and impairment of renal and thyroid functioning (Geller & Luby, as cited by the U.S. Department of Health and Human Services). Lithium is not recommended for families unable to keep regular appointments that would ensure monitoring of serum lithium levels and of conflicting effects. Relapse also is high for those patients who discontinue the medication.

The NIMH (2000) emphasizes that use of antidepressants to treat depression in a child with bipolar disorder may induce manic symptoms if it is taken without a mood stabilizer, such as lithium or valproate. Also, psychostimulant medications used in treating co-occurring ADHD in a child with bipolar disorder may exacerbate manic symptoms (Focus Adolescent Services, 2000).

The child's psychiatrist should be consulted if this occurs and treatment for bipolar disorder may need to be evaluated.

Treatment of Dsythymic Disorder

According to the AACAP (1998), research supports the use of psychotherapies of varying degrees, including psychoanalysis, psychodynamic, psychotherapy, and cognitive behavioral therapy (CBT). Because there is an absence of specific studies on treatment of children with dysthymia, clinicians are advised to utilize treatment modalities appropriate for children diagnosed with major depressive disorder.

Unproven Treatments

Several treatments have been found to be ineffective in treating depression. Available evidence indicates that the cyclic antidepressants are not efficacious (Emslie & Mayes, as cited by Klein et al., 2005). The National Depressive and Manic-Depressive Association (2001) recognizes that various alternative treatments may have a positive effect on mood disorders but assert that such treatments ought not to be endorsed. The Association asserts there is no scientific data supporting the use of dietary supplements such as Omega-3, St. John's Wort, or SAM-e. Furthermore, these supplements may have harmful side effects. Accordingly, such supplements and their use must be discussed with the clinician treating the child.

Cultural Considerations

As indicated by Yaylayan (2002), culture can influence how children communicate symptoms of mood disorders. Complaints of nervousness and headaches are more common among Latino and Mediterranean cultures. Furthermore, complaints of weakness or weariness are more prevalent among the Asian culture.

As noted by Kaslow & Thompson (1998), there is a noticeable deficit of cultural information regarding the treatment of mood disorders in children, as most studies conducted were with children who were middle-class and Caucasian. Moreover, little attention was paid to the relevance of the materials and interventions employed in treatment, as well as to the clinician's education about cultural differences. More research is being conducted into the impact of culture on the assessment and treatment of mood disorders.

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Organizations/Weblinks

American Academy of Child & Adolescent Psychiatry
Virginia Council of AACAP - P.O. Box 71656 - Richmond, VA 23255-1656
804-754-1200
http://www.aacap.org

American Foundation for Suicide Prevention (AFSP)
120 Wall Street, 22nd Floor - New York, NY 10005
888-333-AFSP (2377)
E-mail: inquiry@afsp.org
http://www.afsp.org

The Bipolar Child
http://bipolarchild.com

Bipolar Kids Home
http://www.geocities.com/EnchantedForest/1068

Center for Effective Collaboration and Practice (CECP)
1000 Thomas Jefferson St., NW, Suite 400 – Washington, DC 20007 888-457-1551
http://cecp.air.org

Child & Adolescent Bipolar Foundation
1187 Wilmette Ave., P.M.B. #331 - Wilmette, IL 6009l
http://www.bpkids.org

Depression and Bipolar Support Alliance (DBSA) (formerly the National Depressive and Manic Depressive Association)
730 Franklin Street, Suite 501 - Chicago, IL 60610
888-288-1104
http://www.dbsalliance.org

Depression and Related Affective Disorders Association (DRADA)
2330 West Joppa Road, Suite 100 - Lutherville, MD 21093-4605
888-288-1104
http://www.drada.org

Federation of Families for Children's Mental Health
National: 703-684-7110
http://www.ffcmh.org/index.htm

State: Richmond PACCT (Parents and Children Coping Together)
P.O. Box 26691 - Richmond, VA 23261-6691
800-477-0946; 804-559-6833
E-mail: pacct@infionline.net
http://www.pacct.net

Georgetown University Center for Child and Human Development
http://gucchd.georgetown.edu